5. Psychiartrie by Dr. Emil Kraepelin, 7th edition, 1904, p. 561.
6. Manisch-depressives Irresein und Arteriosklerose by Dr. Albrecht. Allg. Zeitscher, f. Psych. Vol. 63, p. 402.
7. Types of the devolutional psychoses by Clarence B. Farrar (Baltimore) Brit. Med. Jonr. Sept. 29, 1906.
8. Melancholie und Depression by Dr. Med. L. Thalbitzer, Allg. Zeitscher. f. Psych. Vol. 62, p. 785.

Discussion.

Dr. P. K. Brown, San Francisco: It is surprising the number of cases that come into the hands of the general practitioner, cases of insanity in individuals who have never before been insane, and from families where there is no reason to suspect this trouble. In this condition one has to deal with people whose extraordinary ignorance of the usual conditions is usually equaled by that of the physician. Early in my practice it became evident that the most valuable help I could have in dealing with the constant cases was a knowedge of the classification of these cases and an idea of the prognosis, because of the influence it always has in enabling one to advise what had best be done. I arranged with great interest a number of cases in this manio-depressive class of insanity. I get cases where I see that their symptoms months before would have been diagnosed as melancholia or neurasthenia. I recall a case of a personal friend who had the habit of wandering about the streets at night because of sleeplessness. The condition of muscular instability and first manifestations of acute mania came during one of these night wanderings when he saw a man talking loudy to a woman, and the result of his wild interference landed him in an institution. I was impressed with the fact that there was an unusual religious period of two or three months, as far back as six months. That there was a period of great mental activity, when he did an enormous amount of writing on subjects in which he was not ordinarily interested. I have had cases in the last two weeks, cases of manio-depressive insanity. After watching the patient one can sit down with the family and trace out incidents that should have been recognized by the family physician. I wish to emphasize what Dr. Hoisholt has said about the preliminary period of depression and the period in which there is very often marked evidence of increased religious feeling. This is the characteristic in a number of cases I have seen, and it is so distinct that mania occurs almost like the chill in malaria after a period of fever.

Dr. Gardner, San Francisco: I have been very much interested in this paper. If Kraepelin himself in the diagnosis of this insanity cannot place about 50% per cent of his cases, then I think the general practitioner may be excused for some of the mistakes mentioned. There is an excuse for the mistakes to a general extent, in that the general practitioner does not frequently come in contact with cases of this kind, and then only for a short period. The form of insanity the Doctor has called attention to is a new classification and a good one, in that many times we come in contact with cases where the maniacal condition makes us doubt whether to classify it as melancholia.

Dr. Hoisholt, Stockton: In studying these diseases one is dealing with an organ that does not secrete or excrete any substance that will enable one to learn something more definite with regard to its healthfulness. Kraepelin has tried to ferret out the nature of the disease that he studied and the only way to do that is to learn in the history of the case and the actions of the patient the way in which it is violating laws. I wish to lay stress upon this in connection with the study of insanity, that one must not stop with that but go into the study of the manifestations in the way that they deviate from the normal. The man in the asylum does not see these cases in the early stages. The only way to make progress in the knowledge of these cases is to pursue careful study of them before they arrive in the asylum. Opportunity of that kind can be afforded if the colleges had a clinic where the patients could come and the early stage could be outlined before leaving that institution. With regard to the frequency of the disease, I think that perhaps more than 15% will be reported later on. There is only one disease which is more frequent than that, and that is alcoholism.

SYPHILIS—EXTRA-GENITAL CHANCRES.*

By RALPH WILLIAMS, M. D., Los Angeles.

The subject of the extra genital mode of infection is of great interest to us and to society in general.

First: Because it is possible for any one thus to acquire a dangerous and mutilating disease in so many different ways, and to have their whole life made miserable, for no matter in what manner contracted, the disease by the laity is regarded as directly venereal or as hereditary, and carries with it a certain disgrace.

Second: As a value to society, for the reason that if there had been more cases of extra-genital infection, society, which at present even tabooes the name, would have looked upon the disease in its proper light, not as a punishment of vice, and of necessity as an indication of loose morality; but as a constitutional disease with the possibility of it being acquired by both a mediate and immediate manner of infection; possessing to its victims a danger, reaching into the lapse of years, and capable of being transmitted to their progeny. A knowledge of syphilis (old as man—protean as the devil) possessed by society would teach it to be more careful, more cleanly in the use of various articles, and realizing the dangers of this disease and having been taught the many avenues of infection, the people would have better understood and more generally aided in the subjugation of it and other diseases through the propagation of the many great sanitary reforms of recent years, or those which are to follow as prophylactic medical science mounts ever to its ideal. Society in general can hardly be blamed for its ignorance when we consider the fact that so many extra-genital chancres are never even suspected by the general medical man until the roseola or the mucous patch spurs his memory to the fact that even old friends may sometimes change their residence.

Case 1, September, 1900.—A miner, 40 years old, came to Los Angeles to have some dental work done. It became necessary to pull a left lower wisdom tooth. The laceration filled and apparently healed, but about 16 days later became sore and slightly swollen. He was treated by the dentist for several days. About twenty-three days after the ex-

*Read at the Thirty-seventh Annual Meeting of the State Society, Del Monte, April, 1907.

traction the patient was sent to me by a third party. At this time there was an irregular ulceration of the gum where the tooth had been, tender to the touch, and extending to buccal edge of the gum. The ulcer was depressed in the center, practically no discharge, the base was puffy, edges hard and marked by a reddish brown line. There was both submaxillary and anterior auricular glandular enlargement. The specific nature of the ulcer was suspected, the method of infection being divided between the dentist and a "trip down the row," to which the patient confessed. The ulcer did not heal under various applications, but did get smaller and harder and was still present when the roseola appeared nine weeks after the extraction of the tooth. Then, under constitutional treatment, there was a rapid healing of the chancre, which, previous to the appearance of the cutaneous eruption, had become similar to an ulcerated mucous patch.

Case 2, January, 1901.—Also a miner, who came to the city for the treatment of an ulcerated tooth, the major portion of which had been removed some six months previous, and which had for a week been painful and swollen. The remaining piece was removed, but the gum did not heal and he came to the medical college two weeks later. He admitted having smoked at times, for a month before coming to town, the same pipe as was used by his partner. At this time, viz., two weeks after extraction of root and three weeks after noticing a sore gum, there was a linear ulceration along the edge of the gum at the side of the upper, right, second molar; very little tenderness, shallow, no infiltration of base and a yellowish line along the edges. The first patient being still under treatment, this one was at first suspected of being similar, although glandular enlargement was very slight and the ulcer healed under the use of silver in two weeks. One month later the man returned to the clinic with the site of former ulceration presenting the fungating appearance of an ulcerated mucous patch, also others upon the tongue, together with a faint macular rash of the skin, which ten days later was well marked. There was no other sign of a possible primary lesion.

Case 3.—The following was possibly a chancre of the tonsil. Mr. X., known to author for several years, morals reasonably good, gives the following history: On April, 1904, there appeared a rash on face, body and legs. Previous to this he had been under treatment for deafness of the left ear, during which time he had developed an ulcerated tonsil, which while not very sore, was slow to heal. In the latter part of May following he presented a small papulo postular syphilide of face, and especially legs. He said that he had been taking some homeopathic blood medicine, and it did appear to be a mixed specific and iodide rash. There were two mucous patches in the mouth and post cervical glandular enlargement. A thorough search failed to show any sign of a chancre. All lesions rapidly cleared up under anti-luetic treatment, except the stains upon the legs, which are unusually marked upon the very white skin.

Will now report two cases of chancres of the female breasts, with photographs of one of them.

Case 4. July 18, 1897. Mrs. P., 27, three children, presents a typical hard chancre upon each breast, contracted from nursing "a neighbor's baby which died when seven weeks old and had crusts and scales all over it and looked like an old man"—her own words. The chancres appeared two months after having the infant to breast. Neither her eight-months-old child nor her husband have become infected, although there is a well marked papular syphilide upon body and mucous patches in her mouth, vulva and on her breast. She suffers from fever, headache and dizziness. She ceased nursing the child after the sores appeared; just how long she nursed the baby the notes fail to show.

Case 5. October, 1900. A beautiful woman, age 25, grass widow. Having accidentally met her one day and noticing a mild rash on her forehead, jokingly asked her if she had the measles. She said she had tried to see me that day, and then gave the following details: For several days she had had a cold in the head, and after a warm bath the rash had appeared. On examining her face and chest she did seem to have the measles, but there was something wrong with the character of the rash, and she was requested to come to my office the following day. While her social position was fairly good, there was reason to suspect that she was no relation to Caesar's wife. In the daylight and a thorough examination of body there was found under the right breast a small, flat ulcer, partly healed and covered by a thin, black crust. This, she said, had been present for several weeks; she did not know how long. The edges were hard and it was painless and two enlarged axillary glands could be felt. On her wrists were several characteristic papules of syphilis; there was no sign of any genital lesion and the mouth was clear. So like measles was the rash that we waited for several days. The patient, who had been a nurse, had suspected the possible nature of the disease from the line of the examination and questions asked and had said that if the sore was a chancre she knew from whom she had contracted the virus. The subsequent history was a full development of the rash and mucous patches, with a papular syphilide which returned at times for two years, especiallv if she painted in oils.

The following three cases present the initial lesion upon the lips:

Case 6. September, 1899. Well marked chancre on right side of lower lip, present six weeks; small papular rash on body and numerous patches on tongue. No special history of the mode of infection.

Case 7. Miss S., age 20, seen in consultation with Dr. Nickol Smith of Los Angeles. Indurated ulcer, size of a quarter, on upper lip, painful to touch, and bleeds easily; both submaxillary glands enlarged, roseola just appearing on chest and arms, infected probably by kissing. The girl was very nervous and hysterical, had headaches and was pale, so besides being warned against allowing any one to kiss her, little was said to her at the time.

Case 8. March 6, 1905. Mrs. R., age 35, widow; seen in consultation with Dr. La More. Chancre size of a dime in center of upper lip; said she had a cold sore there for six weeks which never healed. Both submaxillary glands enlarged, ulcer hard and painful, is dizzy, pale and has headaches, no rash. One month later Dr. La More 'phoned me she had a well defined syphilide.

The two following cases are almost genital and are reported to show the photographs and the peculiar size and location of the ulcers, the manner of infection, etc.

Cases 9 and 10. The photographs only are shown, as the notes have been lost. You see by these that these men have large oval ulcers presenting all the clinical signs of a chancre, situated just above pubes. The meeting of these two hoboes at the time the photographs were taken was unique, their remarks vivid. No questions on my part were needed to establish the fact that both had become infected from the same source in the same manner.

Case 11. Age 25. F. W. B. consulted me on

the 4th day of October, 1906, and, strange to relate, presented almost the same appearance as cases 9 and 10, both as to size and location of lesion. Owing to this man's intelligence, he being a traveling salesman, I began to hope that here I might find an explanation of the manner in which the virus had become inoculated, but he was unable to give any information except to say that he remembered that about the time of exposure there was a certain amount of irritation in this region, and he had indulged in scratching. The lesion was four inches above the Poupart ligament and slightly to the left of the median line, oval in outline and about one-half inch across. It had appeared between three and four weeks after exposure. Full secondary manifestations were present.

Case 12. Age 33. J. A. S., an advertiser, came to my service at the Medical College Dispensary December 11 with a history of having had for the past eight weeks a slowly enlarging ulcer in the right ear; this ulcer had begun within the external auditory canal as a small pimple; previous to its beginning he had not been under the care of any aurist, consequently we may eliminate infection from an ear speculum. That he had been exposed in the usual manner about this time he did not deny, but this was the only primary lesion that could be found. At present he has a hard indurated ulcer completely encircling and closing the external auditory canal and spreading around this aurifice nearly an inch in all directions, and apparently causing the cartilage of the ear to assume a cracked stellate arrangement with a rather free discharge and swelling of the ear in general. There is also a very decided enlargement of all the anterior-sternoid glands, extending well down the neck. Two weeks ago there appeared a general maculo-papular rash over the face and body. The mouth is clear, general health good with the exception of deafness in this ear, otherwise he presents slight symptoms of the ordinary secondary constitutional disturbance.

Disappeared from sight until April 7th last, when he came to my office for treatment of ulcerated lesion on forehead above left eye, the size of a quarter of a dollar.

Case 13. In February, 1906, there appeared at my clinic a boy of 16 years of age who presented upon the anterior and inner surface of the upper third of the right thigh two large oval ulcerations about three-quarters of an inch in their longest diameter. These lesions had appeared without any appreciable cause so far as he knew. They presented all the characteristics you would naturally expect for chancres in this location. He did not deny a possible exposure. They were recognized and treated as such, except that no constitutional measures were resorted to until after the appearance of a secondary rash, which occurred about seven weeks after he first noticed ulcers.

Case 14. Some time ago I saw in consultation a patient whose work brought him in contact with dead bodies in post-mortem rooms. He gave a history of having assisted in the performance of a post-mortem upon a man twelve hours after death by violence. He wounded his finger, and there occurred septisaemia, with, however, the formation of an ulcer, which was very slow to heal. This ulcer I never saw, for he came to me after it had healed, and at the time of the appearance of a papulo eruption on the chest, abdomen and arms. He also had at this time right axillary enlargement and the submaxillary glands also. I have never been able to find out whether the individual upon whom the post was performed had syphilis or not. The patient stated that so far as he knew there had been no other method whereby he might have become infected. I would like to know from members of the society whether they have ever known of an infection positively from a dead body.

TABES AS IT PRESENTS ITSELF TO THE GENERAL PRACTITIONER.*

By H. C. MOFFITT, M. D., San Francisco.

Tabes, like diabetes, chronic nephritis or exophthalmic goitre, may knock first at the door of the clinician, the surgeon or the specialist. It wears many masks besides the one of Hutchinson, and, in my experience, too often passes unrecognized. Those who have opportunity to observe, over long periods of time, patients infected in earlier years with syphilis, will appreciate what Fournier aptly termed the "initial polymorphism" of tabes. Not enough attention is given, as a rule, to analysis of the subjective symptoms of a patient. Pain, even indefinite peculiar sensations that can with difficulty be put into words, are often hints of beginning organic disease. The inetrcostal neuralgia or sciatica of yesterday becomes the initial pain of tabes in the light of the more careful analysis of to-day. The lessons of tabes, like those of brain or spinal tumors, of exophthalmic goitre, of parathyroid disease, of osteo-arthritis should teach due caution in the use of such labels as "neurasthenia" and "functional disease."

No one at this day should confound typical pains of tabes with rheumatism and sciatica, and yet the mistake is constantly made. Lightning pains frequently come in definite attacks, and are often influenced by weather. In a man seen recently, severe pains followed each rise of temperature occurring in the course of his chronic pulmonary tuberculosis. A man seen some years ago had typical leg pains following attacks of pain in the stump of an arm amputated years before. As in many painful stumps, the pain was referred to an absent hand that, as time went on, came nearer and nearer the stump. Finally, after a particularly painful spell, the hand seemed to join the stump, there were no subsequent attacks of stump pain and, more curious, no recurrence of lightning leg pains.

In four of my cases an intractable recurrent intercostal pain has been an early symptom. Ulnar pain and paresthesiæ have become, since Charcot's time, of great import. Cutaneous hyperesthesia may take the place of pain, and purpura or herpes may follow the track of pain.

A man seen in 1900 had for four years suffered terribly from trigeminal neuralgia. This had been bilateral—a fact almost sufficient to rule out true neuralgia—but was worse in the left upper jaw. All the teeth had been pulled two years before, leaving an open ulcer, and the jaw had been twice operated upon. The tabes had not been recognized because not suspected. In a woman seen five years ago, trigeminal pain and loss of many sound teeth had been an early symptom. The severe—even terrible—trigeminal neuralgia of tabetics is post-ganglionic, and operations do not relieve; in a man

*Read before the San Francisco County Medical Society, September, 1907.